The cases of facial paralysis which he (the speaker) had seen were due either to pathological processes over which the surgeon had very little control, or to an error in surgical technique. He was not familiar with the type of case in which paralysis had ensued as a result of injudicious cauterization. Cauterization in his cases was carried out only at a much later stage, when the facial nerve was well protected by granulations.

He believed that the scarcity of cases of facial paralysis seen in this country might be due less to the caution of British surgeons than to their over-timidity in bevelling down the posterior meatal wall, thus increasing the difficulty of the after-treatment.

Mr. LIONEL COLLEDGE said that in the cases which recovered signs of recovery had almost always appeared by the end of four months. If no signs had appeared at the end of six months, recovery was unlikely; if none were evident at the end of a year recovery was extremely improbable. Cases which recovered spontaneously after a longer interval must be so exceptional that it was not justifiable to take them into account in arriving at a decision about the anastomosis operation. Still, the two cases he (the speaker) was now exhibiting showed that recovery could take place two or even four years after the onset of the paralysis. Sir William Milligan had insisted on the importance of treatment in the meantime, but neither of these patients had had any such treatment, so that apparently this was not essential to the recovery of the muscles.

It should be strongly emphasized that, whatever nerve was employed in the operation, the whole trunk should be employed. If a mere end-to-side anastomosis was made there could be no hope of dissociated movement.

Dr. C. P. SYMONDS said that one explanation of some of these cases of long-delayed recovery was that we were dealing with a functional perpetuation of what had been an organic disability. As Dr. Buzzard had pointed out, a patient with facial palsy learned to inhibit the movement on the other side of the face to some extent, and was, as it were, "going slowly" with the whole of his face. If one allowed the patient to be merely passive and simply treated him by massage and electricity, there was the danger that when regeneration occurred he might not exploit it adequately. Thus there was much to support Dr. Buzzard's argument that attempts at active movement should be combined with massage, the patient being encouraged frequently to practise movements in front of the mirror.

ILLUSTRATIVE CASES.

Post-operative Facial Paralysis.

By DAN MCKENZIE, M.D.

A BOY, aged 3. Schwartze's operation eighteen months ago; complete facial paralysis left, noticed day after operation.

Recovery is progressing. Note an unusual feature, the replacement of the normal closure of the left eyelid in spontaneous winking by a twitch at the angle of the mouth.

Glosso-pharyngeal Facial Anastomosis for Facial Palsy following successful Trans-labyrinthine Drainage for Meningitis.

By E. WATSON-WILLIAMS, M.C., F.R.C.S.Ed.

MRS. L. J., aged 56. Admitted February 11, 1926, with purulent meningitis; labyrinth "dead." At operation the whole labyrinth found destroyed by large cholesteatoma, through which facial nerve ran. Posterior fossa drained through internal auditory meatus; facial nerve divided. Complete facial paralysis with reaction to degeneration.

October, 1926.—Proximal end of glosso-pharyngeal nerve (excluding nerve to stylo-pharyngeus) united end-to-end to facial nerve, divided at the stylo-mastoid foramen.

December 1.—Flabbiness of the cheek felt to be less, and epiphora has nearly disappeared, though no visible change. Now very definite improvement in tone of face, with some capacity for voluntary movement at the corner of mouth and in forehead. In repose asymmetry of face hardly noticeable; no change in electrical reactions.

Hypoglossal-facial Anastomosis for Facial Palsy following Mastoid Operations.

By LIONEL COLLEDGE, F.R.C.S.

CAPTAIN B., aged 32. Mastoid operation in India in 1921, followed by facial palsy fourteen days later. Further mastoid operation in India, and subsequently the wound was re-opened and grafted in London two years after first operation. No recovery of facial muscles, except for slight voluntary movement of the orbicularis palpebrarum.

June, 1923.—Hypoglossal-facial anastomosis with secondary descendens hypoglossal anastomosis. There is electrical recovery to faradism of all facial muscles.

Descendens Noni Facial Anastomosis for Bell's Palsy.

By LIONEL COLLEDGE, F.R.C.S.

MISS A. H., aged 29. Referred by Dr. A. Feiling on account of Bell's palsy, showing no improvement after four years. Reaction of degeneration in all facial muscles of left side. Descendens noni facial anastomosis; descendens found to be appreciably smaller than facial. Peripheral end of descendens implanted into the side of hypoglossal. A year later electrical recovery of all facial muscles and muscles supplied by descendens. No paralysis of tongue.

Spinal Accessory Facial Anastomosis for Facial Palsy during Acute Destruction of Labyrinth.

By C. GILL-CAREY, F.R.C.S.Ed.

MRS. A., aged 29. Acute mastoid, 1924. Nerve paralysed before operation, no recovery. Radical operation, January 1925, did not heal. Labyrinth fell out as a sequestrum, immediate healing. Spinal accessory divided below nerve to sterno-mastoid and joined end-to-end to facial (Mr. C. H. Fagge), October, 1925.

Facial Palsy Five Years After Injury.

By T. B. LAYTON, D.S.O., M.S.

JAMES A., now aged 16. April, 1922, complete facial palsy following attempt at radical mastoid. Injury to nerve was outside skull. Radical mastoid performed later. Some recovery of power.